HEALTHTrust
DELIVERING MEALS on WHEELS

Greetings from Meals on Wheels, sponsored by The Health Trust!

Our mission is to provide nutritious daily meals, social interaction, and in-home wellness services for homebound, frail, and disabled adults, helping them to retain their independence.

You may qualify for this program if you:

- Are a resident of Santa Clara County
- 18+ years of age
- **Homebound:** Mostly home except for medical appointments
- Have difficulty shopping/cooking
- Do not drive or work

Contributions for meals are greatly appreciated, recommended amount is $11/per day. **Grant funding is available** for low-income clients.

Weekly frozen meals: Delivered 1x per week, Monday – Friday between 9:00 AM - 3:30 PM

- Meals Meet Nutrition guidelines of the Older Americans Act
- All meals are considered low sodium
- Locally prepared
- **No** trans fats, high fructose corn syrup, hormones, preservatives, chemicals, antibiotics.

If you are interested in applying for our program, please review carefully the enclosed packet of forms and information. Then complete, sign, and return the *complete* forms to:

Meals on Wheels, 3180 Newberry Dr., Suite 200, San Jose, CA 95118

FORM	DESCRIPTION	TO DO	
Client Information / Application Form (pg. 2)	*Detailed application (4 pages, double-sided) for you to note information to help us provide meals*	**Complete BOTH SIDES, sign your name and date at the bottom**.	☐
Private Pay Service Agreement (pg. 4)	*Private Pay service agreement information*	**Please read and sign if you are contributing for the cost of meals.**	☐
Notice of Privacy Practices (pg. 5)	*Information only*	Please read.	☐
Acknowledgement – Notice of Privacy Practices (pg. 6)	*You verify that you have read the privacy policies*	**Print your name, sign your name and add the date.**	☐
Policy – Client Discharge from Services (pg. 7)	*Criteria for discharging a client from MOW Program*	Please read.	☐
Acknowledgement – Discharge from Services policy (pg. 8)	*You verify that you have read the discharge policy*	**Print your name, sign your name, and add the date.**	☐

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Additional Complimentary Services:

- Wellness check and visit
- Case management support and referrals
- Information on local services/resources and educational materials
- Fall Prevention Program with Stanford Medical Center

Call our office at: 408-961-9870 or 800-505-3367
Email: MOW@healthtrust.org
Fax #: 408-265-2749

Office Hours:

Monday—Friday
8:00 AM—4:00 PM

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NEW CLIENT INTAKE FORM

Last Name:	**First Name:**
Marital Status: ☐ Single ☐ Married ☐ Widowed	***Do you work or drive?:** ☐ Yes ☐ No ☐ Both
Birth Date: / / **Age:**	**Sex at birth:** ☐ Male ☐ Female ☐ Decline to State
Sexual Orientation: ☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian ☐ Decline to State ☐ Not Listed, Please Specify: _____	**Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Gender Queer/Non-Binary ☐ Decline to State ☐ Not Listed, Please Specify: _____
Address: **Apt. #:**	**City:** **Zip:**
Cross Street (if any)**:**	**Phone Type:** ☐ Mobile ☐ Home ☐ Work
Email: ☐ Do Not Email	**Phone #:**
Delivery Notes:	**Do you live in:** ☐ Apartment ☐ Mobile home park ☐ Duplex/4plex **If marked any of the above, is there a special code or instructions to enter?:** _____ _____ **Do you have a pet?:** ☐ Yes ☐ No **Pet(s) at home:** ☐ Dog ☐ Cat
Social Security #: _ _ _ - _ _ - _ _ _ _ ☐ Mark here if no SSN	**Mother's Maiden Name:** _____
Are you homebound due to illness, disability, or isolation? ☐ Yes ☐ No	
Health Insurance:	☐ MediCare A ☐ MediCare B ☐ MediCare D ☐ Medi-Cal ☐ CalMediConnect ☐ Other: _____ **Health Insurance Provider(s) and #:** _____
Other details (if applicable): ☐ Rural ☐ Calfresh (Food Stamps) ☐ In Home Support Services (IHSS)	
Veteran Status?: ☐ Yes ☐ No	**Spouse of Veteran?:** ☐ Yes ☐ No
Do you live alone?: ☐ Yes ☐ No **If marked "No," who do you live with?** _____ **# in Household:** _____	
Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Not Listed, Please Specify: _____	

The Health Trust—Meals On Wheels
Tel: 408-961-9870 Fax: 408-265-2749
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All contents of this packet updated: Jan 29, 2024

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BACKGROUND INFORMATION	**Ethnicity:** ☐ Hispanic, Latino, Spanish Origin ☐ Not Hispanic/Latino **Race:** *(Please check as many that apply to you)* ☐ American Indian or Alaska Native ☐ Korean ☐ Black or African American ☐ Laotian ☐ Cambodian ☐ Native Hawaiian or Other Pacific Islander (Hawaii, Guam, Samoa, Other) ☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Filipino ☐ White (Origins of Europe, Middle East, or North Africa)
MEALS	**Meal quantity requested*:** ☐ 3 ☐ 5 ☐ 7 **Serving only regular diets. All meals are considered Low Sodium. Cannot accommodate allergies. Minimum of 3 meals/week.* **Meal Type (choose one):** ☐ Frozen (delivery 1x/week) ☐ Hot Meal* **Hot Meals are American diet only, delivered daily & require approval.* **Beverage (choose one):** ☐ Low-fat Milk ☐ Juice ☐ None **Do you eat:** ☐ Pork* ☐ Fish* **Fish & pork meals can be substituted. No other subs allowed.* **Menu Type (choose one):** ☐ American ☐ Asian Fusion ☐ Vegetarian
HEALTH STATUS *(Please check as many that apply to you)*	☐ Arthritis ☐ Cardiovascular/Heart ☐ Dementia, Alzheimer's ☐ Diabetes ☐ Glaucoma ☐ Impaired Hearing ☐ MS, Parkinson's, Lou Gehrig's ☐ Legally Blind/Visually Impaired ☐ Respiratory ☐ Tooth/Mouth/Throat ☐ Stroke ☐ Other: _____ **Mobility Aids:** ☐ Bedridden ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair **Mental Health:** ☐ Alert ☐ Depression ☐ Forgetful/Confused ☐ Other: _____

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EMERGENCY CONTACT INFORMATION	**Emergency Contact Name:** _____ **Relationship to Client:** _____ **Street Address:** _____ **City:** _____ **Zip:** _____ **Phone Type:** ☐ Mobile ☐ Home ☐ Work **Phone #:** _____ **Email:** _____ **Emergency Contact Name:** _____ **Relationship to Client:** _____ **Street Address:** _____ **City:** _____ **Zip:** _____ **Phone Type:** ☐ Mobile ☐ Home ☐ Work **Phone #:** _____ **Email:** _____
BILL-TO-INFORMATION	**Billing Contact Full Name:** _____ **Relationship to Client:** _____ **Phone Type:** ☐ Mobile ☐ Home ☐ Work **Phone #:** _____ **Email:** _____
REFERRAL INFORMATION	**Referral Full Name:** _____ **Relationship to Client:** _____ **Phone Type:** ☐ Mobile ☐ Home ☐ Work **Phone #:** _____

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PERCEIVED HEALTH *(Please check one)*	**In general, would you say that your health is:** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

ADL/ACTIVITY CLIENT DOES DAILY

(For each activity, please select one if it applies to you)

Eating	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Dressing	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Transferring	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Bathing	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Toileting	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Walking	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
	Total Points: _____ ***(FOR OFFICE USE ONLY)***

IADL/INSTRUMENTAL ACTIVITY CLIENT DOES DAILY

(For each activity, please select one if it applies to you)

Money Mgmt	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Shopping	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Meal Preparation	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Light Chores	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Laundry	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Telephone	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Meds Mgmt	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Heavy Chores	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
Transportation	☐ Dependent ☐ Independent ☐ Lots of Help ☐ Some Help ☐ Virtual Assist
	Total Points: _____ ***(FOR OFFICE USE ONLY)***

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NUTRITIONAL RISK ASSESSMENT

(1) - I eat alone most of the time.	☐ Yes ☐ No
(1) - I take 3 or more different prescribed or over-the-counter drugs per day.	☐ Yes ☐ No
(2) - I have an illness/condition that changed the kind and/or amount of food I eat.	☐ Yes ☐ No
(2) - I eat fewer than 2 servings of fruits or vegetables or 1 serving of dairy products a day.	☐ Yes ☐ No
(2) - Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐ Yes ☐ No
(2) - I have 3 or more drinks of beer, liquor or wine almost every day.	☐ Yes ☐ No
(2) - I have tooth or mouth problems that make it hard for me to eat.	☐ Yes ☐ No
(2) - I am not always physically able to shop, cook and/or feed myself.	☐ Yes ☐ No
(3) - I eat fewer than 2 meals a day.	☐ Yes ☐ No
(4) - I don't always have enough money to buy the food I need.	☐ Yes ☐ No
Total Points: _____ [6+ Points = High Risk] ***(FOR OFFICE USE ONLY)***	

ADDITIONAL INFORMATION	**Do you have a Social Worker?:** ☐ Yes ☐ No **Do you have a Case Manager?:** ☐ Yes ☐ No **Social Worker/Case Manager Name:** _____ **SW/CM Organization/Hospital:** _____ **SW/CM Phone #:** _____ **SW/CM Email:** _____ **Should be listed as Emergency Contact?:** ☐ Yes ☐ No **Is client physically & mentally able to prepare/reheat meal?:** ☐ Yes ☐ No

Additional Notes:

I verify that the information is correct and I give my permission to the MOW staff to disclose my personal health information to my Designated Emergency Contact Person in an emergency. I am aware that Meals On Wheels serves only a regular diet of normal consistency and is unable to accommodate allergies and dietary restrictions.

Client Signature: _____ **Date:** _____/_____/_____

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MEALS ON WHEELS OFFICE USE ONLY	
Verified with client on valid/correct information? ☐ Yes ☐ No	**MOW Personnel Name:**_____ **Initials:** _____
MOW Personnel Checklist	**(1) Intake Form:** ☐ Sent for Client's Signature ☐ Entered into Q database (COA Grant only) ☐ Entered into Salesforce ☐ Placed in Client's file **(2) Service Agreement:** ☐ Sent for Client's Signature
	Salesforce Entry Date: _____/_____/_____ **Delivery Start Date:** _____/_____/_____ **PP/Grant:** _____ **Day of Delivery:** ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

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Meals On Wheels Private Pay Service Agreement

Meals On Wheels provides meal services to individuals 18 years or older, who are homebound and have difficulty shopping or cooking. It costs The Health Trust approximately $11 to provide meals and delivery service to your home.

Your suggested contribution is **$8 to $11.00 per meal, as you do not qualify for a grant.** Our program has a **minimum of 3 meals per week for services**. We require a deposit equal to the amount of seven meals.

Contribution Information:

- You will receive a statement for your meals at the middle of each month for the number of meals received from the prior month**.** Your meal contribution is due upon receipt.

- You can contribute with a check or credit card. Please make checks payable to The Health Trust or call our office with your credit card information.

- If you are not at home when delivery is made, you will still be responsible for the meal contribution. **Meal delivery cancellations must be phoned in to (408) 961-9870 by 10:00 a.m. the day before delivery.**

- Meals On Wheels has the right to terminate services for any reason due to safety, accessibility, and communication.

Client Service Agreement:
I have agreed to contribute $ for the cost of each meal, with a start-up commitment of one week. If I am not at home when the delivery is made, I understand that I will still be responsible for the cost of the meal. If I am not at home or if I am ill, I give permission to the Meals On Wheels program staff to contact the emergency number I have provided. The information that I have supplied to The Health Trust is correct to the best of my knowledge.

Client or Responsible Party: _____Signature Date _____

In order to start service, send this form to:

The Health Trust-Meals On Wheels
3180 Newberry Dr., Suite 200
San Jose, CA 95118
408-961-9870 (Office) 408-265-2749 (Fax)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact **The Health Trust at 408-961-9870, 3180 Newberry Dr., Suite 200, San Jose, CA 95118**

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive from our employees, staff and other office personnel.
We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.
Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care
For Payment. We may use and disclose health information about you so that the treatment and services you receive from our organization may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received from us, so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you in order to run the office and make sure that you and our other patients/clients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.
Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).
Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
HealthRelated Products and Services. We may tell you about healthrelated products or services that may be of interest to you.
Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or healthrelated products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Fundraising. We are a community-based, not-for-profit public charity that depends extensively on charitable support. We may use limited information about you, such as your name, address, demographic information, and the dates you received treatment to inform you of opportunities to support The Health Trust and its services and programs.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:
To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Required By Law. We will disclose health information about you when required to do so by federal, state or local law.
Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, nonaccidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable
We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you while receiving a service from us during treatment or service or while treatment or service is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION.

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to The Health Trust in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to The Health Trust. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to The Health Trust. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a particular medical service you received from The Health Trust.

We are Not Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *a Request For Restricting Uses and Disclosures and Confidential Communications Form* Information to The Health Trust.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit *the Requests For Restricting Uses and Disclosures and Confidential Communications* to The Health Trust. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact The Health Trust.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the bottom right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact The Privacy Officer, 408-559-9385, 2085 Hamilton Avenue, Suite 150, San Jose, CA 95125. You will not be penalized for filing a complaint.

MANDATED REPORTING

Health Trust staff are mandated reporters and therefore required by law to make a report to Adult Protective Services (APS) regarding any known or suspected elder abuse or self-neglect.

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ACKNOWLEDGEMENT
NOTICE of PRIVACY PRACTICES

I acknowledge that I have received a copy of Privacy Practices for The Health Trust under the Health Insurance Portability and Accountability Act (HIPAA).

Client/Patient **Print** Name:_____

Client/Patient **Signature**: Date: _____Date:_____

Client/Patient is unable to sign because:

Authorized Client/Patient Representative Signature: _____

Relationship to client:

The Health Trust—Meals On Wheels
Tel: 408-961-9870 Fax: 408-265-2749
3180 Newberry Dr., Suite 200
San Jose, CA 95118

Client Discharge from Services Policy

The Health Trust MOW Program

Policy:
It is the policy of The Health Trust Meals on Wheels program (MOW) to discharge or transfer clients from services according to a standard set of criteria. Clients will be notified of this action whenever possible.

Discharge Criteria:
1. Client death.

2. Client relocation outside of service area.

3. Client no longer meets eligibility criteria. (Client no longer is qualified for program based on Nutritional Risk, ADL and IADL assessments and/or reassessments that determine if he/she is homebound, unable to shop or cook, and 18 years or older).

4. Client is not home to receive scheduled meal delivery and is capable of notifying MOW office for alternate delivery arrangements according to the current MOW meal cancellation policy, but fails to do so on 2 or more occasions within a 30 day period.

5. Client exceeds the 30-day long-hold with services.

6. Client no longer wishes to provide data and receive service, therefore withdraws.

7. Client refuses to provide a safe means for food delivery.

8. Client refuses 6 month reassessment home visits by Case Management staff.

9. If Client/Family/Other is verbally abusive to any MOW employee or volunteer, he/she will receive a verbal warning and possible discharge from service. If client receives a verbal warning and remains on service, no additional warnings will follow. Further verbal abuse is grounds for immediate discharge from service.

10. If Client/Family/Other is physically or verbally abusive or threatens with physical abuse any MOW employee or volunteer, he/she will result in immediate discharge from service.

11. A determination by MOW that continued participation by client will compromise the agency's ability to maintain the safety of the staff and/or volunteers.

12. A determination by MOW that it is no longer able to provide services due to irreconcilable differences with Client/Family/Other.

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ACKNOWLEDGEMENT

DISCHARGE from SERVICES POLICY

I acknowledge that I have received a copy of Discharge from Services Policy for The Health Trust Meals On Wheels.

Client/Patient **Print** Name:_ _____

Client/Patient **Signature**:: _____Date;_____

Client/Patient is unable to sign because:

Authorized Client/Patient Representative Signature:

Relationship to client:

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